The Changing Massachusetts Health Care Environment:
Final Presentation to the Health Care Task Force

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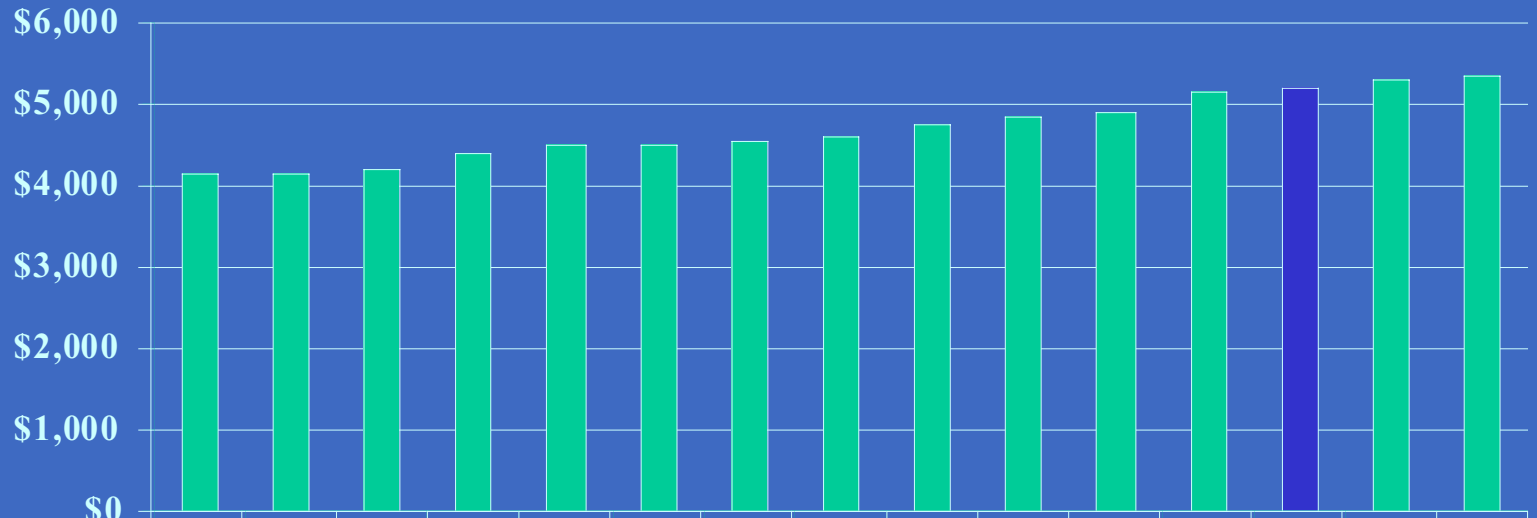
Overview

- Where We Started
- Developments During the Task Force/Working Group Process
- Current Conditions and Concerns
- Areas for Action

Boston Employers' Costs Among the Highest in the Nation

Health Care Costs per Employee, Major Metropolitan Areas, 2001



	San Francisco	Phoenix	Denver	Atlanta	Washington, D.C.	Cincinnati	Chicago	Tampa Bay	Minneapolis/St. Paul	Dallas/Ft. Worth	Philadelphia	Houston	Boston	New York City	Detroit
Physician Rate	$4,160	$4,167	$4,201	$4,430	$4,508	$4,534	$4,586	$4,634	$4,774	$4,883	$4,896	$5,164	$5,230	$5,315	$5,368

Source: Hewitt Associates, Hewitt Health Value Initiative, 2001.

Massachusetts' Medicaid Expenditures Per Enrollee Also High

- Including long-term care expenditures, Massachusetts ranked 7th in per-enrollee expenditures in 1998.
- Excluding long-term care expenditures, Massachusetts ranked 5th.

In Spite of High Expenditures, We Were Seeing

- **HMOs** on the brink of insolvency
- **Hospitals** in severe financial distress
- **Nursing homes** entering bankruptcy
- **Community-based** providers in trouble
- Lower **Physician** income in Massachusetts

Why?

- Several years of little or no increase in private insurance premiums to insurers
- Low hospital payments relative to costs from both private and Medicaid payers
- Medicare changes reduced anticipated federal revenue

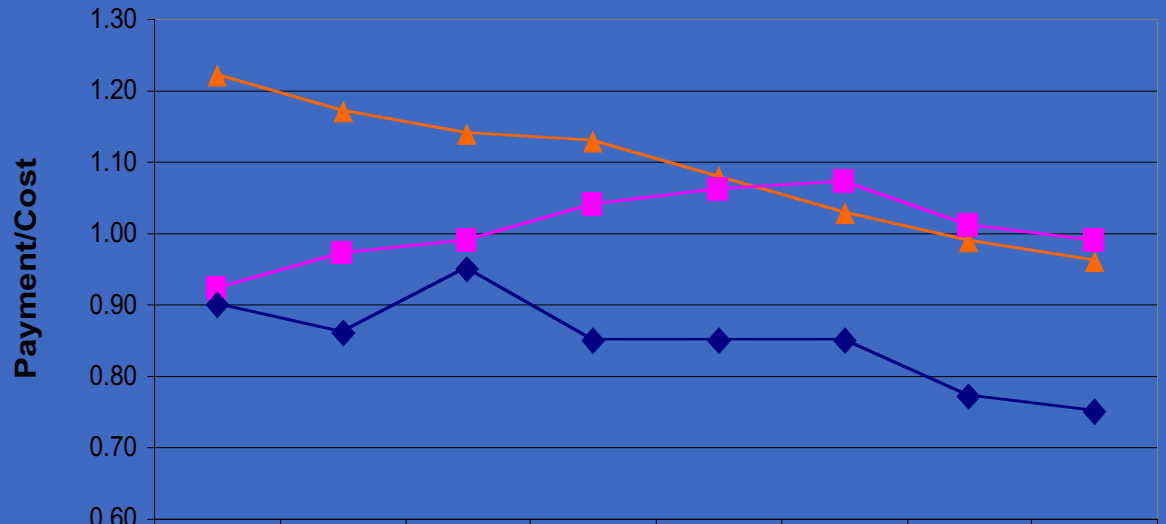
Medicaid and Private Payments to Hospitals Have Been Below Cost

	Medicaid	Private
MA Payment to Cost Ratios	0.75	0.96
Number of States with Ratios **Higher** than MA	43	48
Number of States with Ratios **Lower** than MA	5	1

* The State of Illinois also has the same Medicaid hospital payment to cost ratio.
Source: MedPAC Report to Congress: Medicare Payment Policy, March 2, 2001.

And The Gap In The Medicaid Payment-to-Cost Gap Has Grown Since 1995

Payment to Cost Ratios



	1992	1993	1994	1995	1996	1997	1998	1999
Private	1.22	1.17	1.14	1.13	1.08	1.03	0.99	0.96
Medicare	0.92	0.97	0.99	1.04	1.06	1.07	1.01	0.99
Medicaid	0.90	0.86	0.95	0.85	0.85	0.85	0.77	0.75

Medicaid figures in 1998 and 1999 do not include Medicaid managed care.

Sources: 1992-1998, Lewin. 1999 and Medicaid 1998, MedPAC.

Developments Since Task Force Began. . .

- ***Insurers*** Financial Position Has Improved
- Revenues From Private and Public Payers To ***Hospitals*** Have Increased, But so Have Costs
- ***Nursing Home*** Margins Have Improved Slightly
- Thanks to Improvements in Medicare Payments, ***Home Health Agencies*** Are in Better Shape

Employer/Purchasers Are Paying More

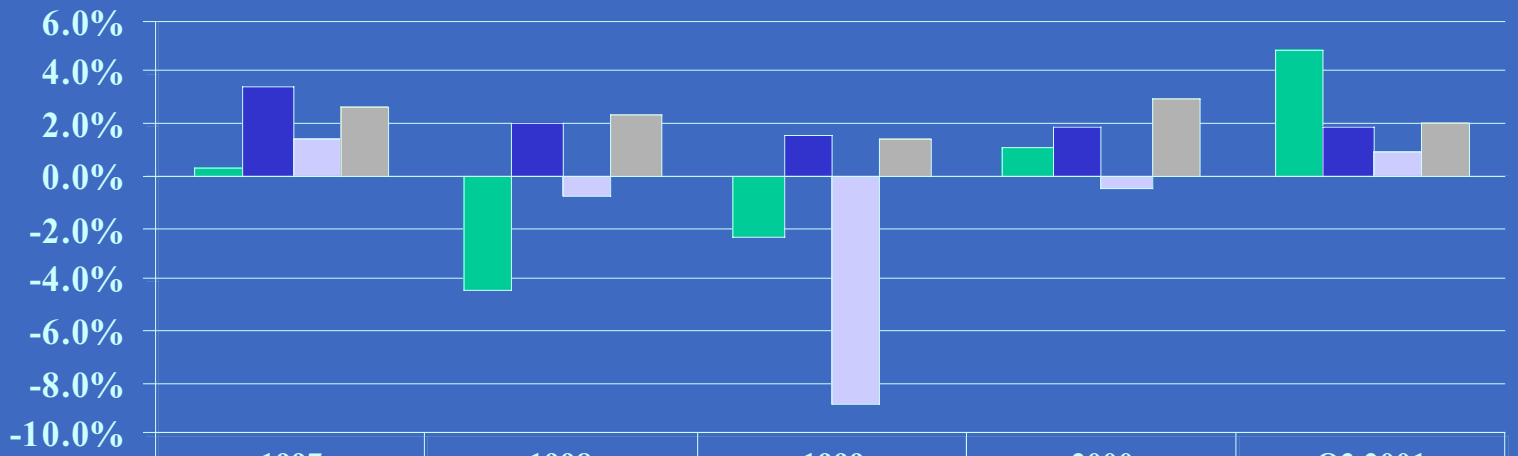
Health Benefit Cost Trend, All Employers

	1988	1989	1990	1991	1992	1993	1994	1996	1997	1998	1999	2000	2001	2002
% change	6.9%	18.6%	16.9%	17.1%	12.1%	10.1%	8.0%	2.1%	2.5%	0.2%	6.1%	7.3%	8.1%	13.0%

Source: William M. Mercer, Incorporated

HMO Financial Conditions Have Improved

HMO Net Profit Margins 1997 - Q3 2001

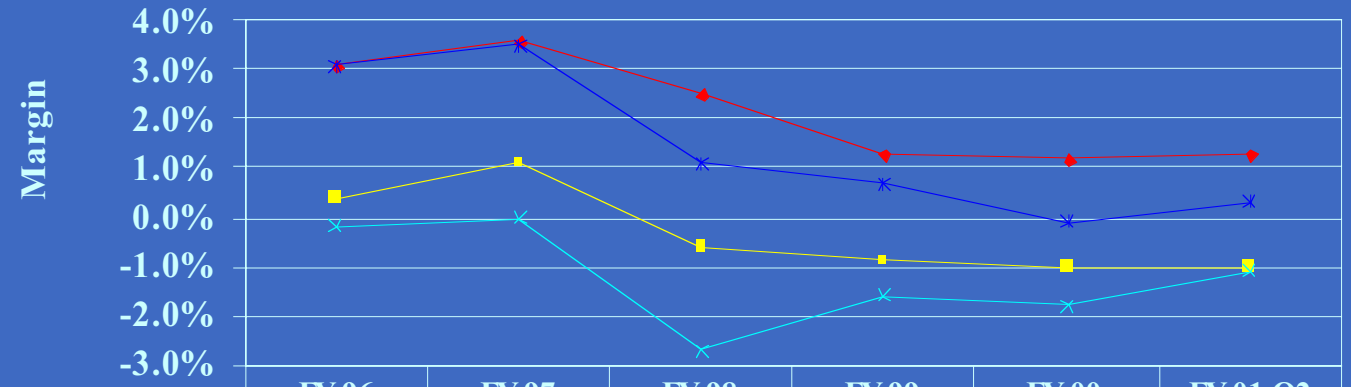


	1997	1998	1999	2000	Q3 2001
Fallon	0.4%	-4.3%	-2.3%	1.1%	4.9%
HMO Blue	3.5%	2.1%	1.7%	2.0%	2.0%
HPHC	1.4%	-0.8%	-8.7%	-0.5%	1.0%
Tufts	2.7%	2.4%	1.4%	3.1%	2.1%

Source: Massachusetts Division of Insurance

Hospital Results are Mixed

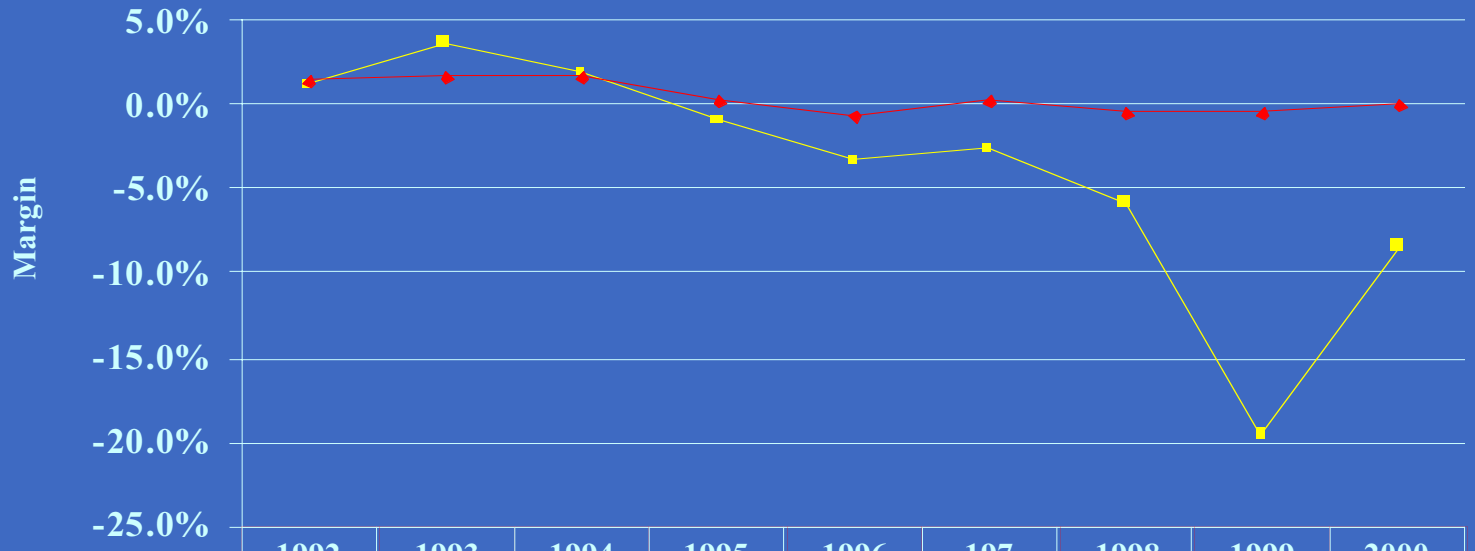
Median Total and Operating Margins FY 1996-2001
Teaching vs. Community Hospitals



	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01-Q2
Total Community	3.1%	3.6%	2.5%	1.3%	1.2%	1.3%
Operating Teaching	-0.2%	0.0%	-2.7%	-1.6%	-1.8%	-1.1%
Operating Community	0.4%	1.1%	-0.6%	-0.9%	-1.0%	-1.0%
Total Teaching	3.1%	3.5%	1.1%	0.7%	-0.1%	0.3%

Nursing Homes are Better, but Still in Serious Condition

Median Total Margin for Nursing Facilities Owned by Currently Bankrupt Entities vs. Facilites Owned by Solvent Entities



	1992	1993	1994	1995	1996	197	1998	1999	2000
Bankrupt Owners	1.18%	3.75%	1.89%	-0.90%	-3.33%	-2.56%	-5.78%	-19.50%	-8.45%
Solvent Owners	1.43%	1.67%	1.65%	0.29%	-0.59%	0.22%	-0.47%	-0.45%	0.00%

Bankrupt	n=65	n=68	n=69	n=73	n=76	n=77	n=77	n=71	n=65
Solvent	n=434	n=447	n=449	n=449	n=449	n=432	n=419	n=412	n=378

Source: DHCFP 403 cost report; FY 01-Q2 from MA Hospital Association Financial and Utilization Survey.

The State has Responded with Increased Targeted Funding

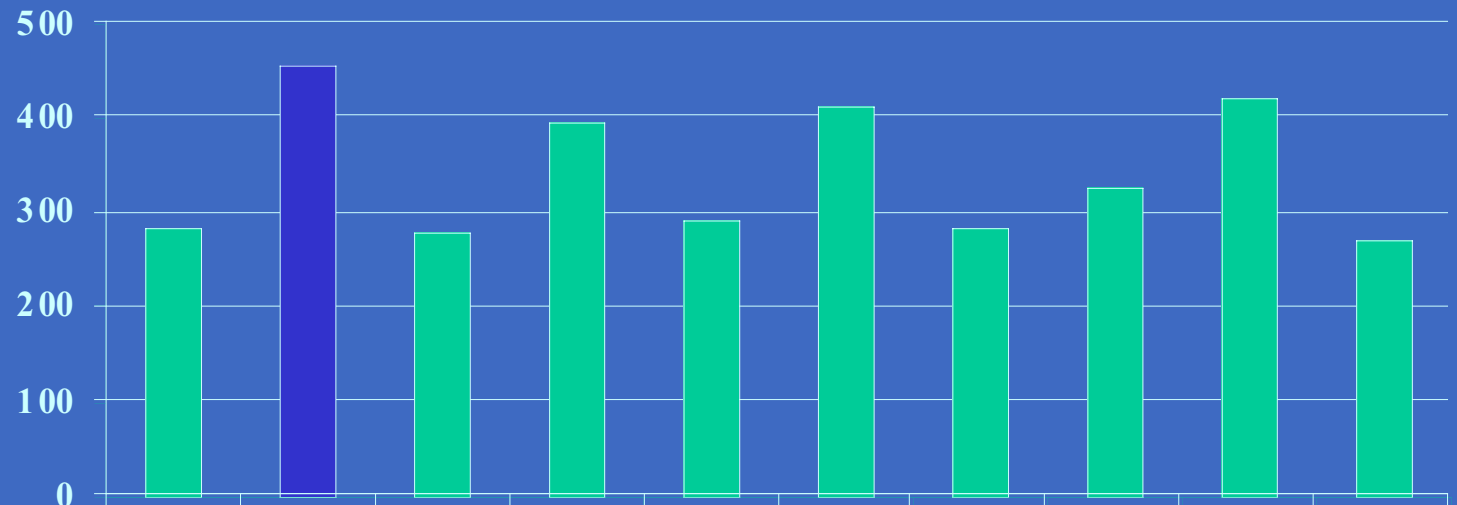
- Targeted Medicaid rate increases for some hospital services
- Increased state funding and reduced hospital assessments for uncompensated care
- Targeted relief for financially distressed hospitals
- Targeted spending on front-line caregivers in nursing homes

Physicians Are Under Pressure

- Physicians are concerned about erosion in practice conditions and payment rates.
- Supply appears to be adequate, though many physicians in Massachusetts do not practice full time.
- Situation should be monitored.

Massachusetts Has More Physicians Than Other States

Rate of Non-federal Physicians per 100,000 Civilian Population, 1999



	US	MA	CA	CT	FL	MD	MN	NJ	NY	WA
Physician Rate	285	454	280	397	290	413	282	327	423	272

Source: AMA, taken from www.statehealthfacts.kff.org

Current Conditions and Concerns

- Increased health care revenue will help Providers and Insurers, But will cause more problems for Employers, Patients and Government
- Need to modify Massachusetts use of higher-cost settings for care
- Loss of volume is hurting lower-cost settings, such as community hospitals and non-hospital outpatient sites

Current Conditions and Concerns

- Medicaid payments to hospitals, in relation to cost, are low and gap is widening.
- Nursing homes continue to need assistance and have few alternatives to Medicaid as a revenue source.
- Economic conditions are likely to contribute to higher Medicaid enrollment.

Areas for Action

- Reduce the Rate of Cost Increases by:
  - Focus on Shifting Use Patterns
  - Encourage Efficiency and Reducing Unnecessary Cost
- Examine Payment and Utilization Patterns of Medicaid
- Insurance Oversight and Maintaining Access to Insurance
- Increase State Monitoring, Analysis and Reporting of Health System

Reducing the Rate of Cost Increases

- Reducing Rate of Increase in Health Care Costs should be a priority for the private and public sectors.
  - Continued double-digit increases in Massachusetts premiums could lead to increased numbers of uninsured and may hurt our attractiveness to businesses.
  - Further increases in cost put pressure on Medicaid, on top of increases resulting from higher enrollment.

Reducing the Rate of Cost Increases: Shifting Use Patterns

- Among factors driving cost increases, changes in use patterns may be most responsive to intervention.
  - The high-cost structure of our system (more teaching hospitals, more specialists) is part of who we are; we might not want to change it even if we could.
  - But more recent trends in higher use of teaching hospitals, outpatient departments and emergency departments are troubling.

Reducing the Rate of Cost Increases: Shifting Use Patterns

- Shifts in patient volume exacerbate our already high costs.
  - Lower-cost settings may close, forcing even more care to expensive settings.
  - Pressure for special assistance to preserve community hospitals would increase costs in short-run but could reduce costs in long-run.

Reducing the Rate of Cost Increases: Shifting Use Patterns

- For Medicaid, which pays based largely on average costs,
  - shift towards higher-cost teaching hospitals from community hospitals increases the hospital payment-to-cost gap; and
  - increased use of hospital outpatient departments and emergency rooms, rather than lower cost settings, increases expenditures

Reducing the Rate of Cost Increases: Shifting Use Patterns

- Tools:
  - use provider and consumer education about quality, financial incentives
  - develop quality improvement initiatives, quality measurement and reporting mechanisms
  - develop quality measurements and improvements that increase attractiveness of lower-cost, community settings

Insurance Oversight and Maintaining Access to Insurance

- Review state requirements to determine if:
  - some that generate cost increases could be eliminated and
  - Whether more oversight of HMOs' financial requirements and pricing practices is necessary
- Evaluate mandated benefits in relation to any premium increases they will entail
- Reduce barriers to benefit designs that might preserve access to necessary services through lower premiums

Encourage Efficiency and Reduce Unnecessary Cost

- Tools:
  - comparative data analysis and reporting on cost and efficiency of providers
  - administrative simplification through collaborative public-private efforts and streamlining government regulation

Examine Aspects of Medicaid in the Changing Health Care Environment

- Re-evaluate annual update or "inflation" factor in payment formulas, adjust to account for unavoidable cost increases
- Incorporate incentives to encourage efficiency and use of lower-cost providers wherever possible, in partnership with providers
- Maintaining eligibility and appropriate payment for services are both important

Increase Monitoring, Analysis and Reporting

- Increased demand for high-cost services requires examination
  - Is there a lack of sufficient access to primary care in community settings, such as physician offices, contributing to higher ED use?
  - Are physician practice patterns and affiliations related to shifts in demand?

Increase Monitoring, Analysis and Reporting

- Cost and efficiency variation across providers should be examined
  - best practices can be identified and shared
  - overall efficiency in resource utilization is a common goal

Increase Monitoring, Analysis and Reporting

- Developing more and better measures of quality and evidence-based practices would improve outcomes and efficiency.
- Reporting of information, coupled with provider and patient incentives, should help to increase efficiency in the system overall.